DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: 00-04

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250 - .280

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ 25,039,343.61
b. FFY 2001 $ 34,254,877.11

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D Pages 1-10
Attachment 4.19-D Exhibit A Pages 1-3
Attachment 4.19-D Exhibit B Entire

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D Pages 1-7
Attachment 4.19-D Exhibit A Pages 1-
Attachment 4.19-D Exhibit B Entire

10. SUBJECT OF AMENDMENT:
Nursing Facility Reimbursement

GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Review delegated to Commissioner Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Allen R. Nesen

14. TITLE: Interim Commissioner
Dept. For Medicaid Services

15. DATE SUBMITTED:
3/31/00

16. RETURN TO:
Sharon Rodriguez
Department for Medicaid Services
275 East Main Street 6EA
Frankfort, KY 40621

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:
**March 31, 2000**

18. DATE APPROVED:
**August 10, 2001**

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
**January 1, 2000**

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
**Eugene A. Grasser**

22. TITLE:
**Associate Regional Administrator**
**Division of Medicaid and State Operations**

23. REMARKS:

FORM HCFA-179 (07-92)

***Instructions on Back***

FACILITY REIMBURSEMENT – METHODS AND PROCEDURES
FOR JANUARY 1, 2000 AND THEREAFTER

The following sections summarize the cost-based and price-based reimbursement methodologies for facilities in Kentucky.

Participation Requirements

To participate in the Medicaid Program, the facilities are required to be licensed as nursing facilities or as an intermediate care facility for the mentally retarded and developmentally disabled. Hospitals providing swing-bed hospital nursing facility care shall not be required to have the hospital beds licensed as NF beds. All nursing facilities (NFs) must participate in Medicare in order to participate in Medicaid, except for those NFs with waivers of the nursing requirements (who are prohibited by statute from participation in Medicare).

Audits

The state agency reviews all cost reports for compliance with administrative thresholds. Costs will be limited to those costs found reasonable. Overpayments found in audits under this paragraph will be accounted for in accordance with federal regulations.

Cost-Based Facilities

The following facilities shall remain in the cost-based facility methodology:

a. A nursing facility with a certified brain injury unit;

b. A nursing facility with a distinct part ventilator unit;

c. A nursing facility designated as an institution for mental diseases;

d. A dually-licensed pediatric nursing facility;

e. An intermediate care facility for the mentally retarded and developmentally disabled; and

f. A hospital providing swing bed nursing facility care.

Cost Reports for Cost-Based Facilities

Facilities shall use a uniform cost reporting form for submission at the facility's fiscal year end. The single state agency shall set a uniform rate year for cost-based NFs and ICF-MRs (July 1-June 30) by taking the latest available cost data which is available as of May 16 of each year and trending the facility costs to July1 of the rate year.

1. If the latest available cost report period cost data has not been audited or desk reviewed prior to rate setting, the prospective rates shall be based on cost reports which are not audited or desk reviewed subject to adjustment when the audit or desk review is completed. If desk reviews or audits are completed after May 16, but prior to universal rate setting for the rate year, the desk review or audited data shall be used.

2. Partial year or budgeted cost data may be used if a full year's data is unavailable. Unaudited reports shall be subject to adjustment to the audited amount.

3. Facilities paid on the basis of partial year or budgeted cost reports shall have their reimbursement settled back to allowable cost.

Allowable Cost

Allowable costs are costs found necessary and reasonable by the single state agency using Medicare Title XVIII-A principles except as otherwise stated. Bad debts, charity and courtesy allowances for non-Title XIX patients are not included in allowable costs. A return on equity is not allowed.

Methods and Standards for Determining Reasonable Cost-Related Payments

The methods and standards for the determination of reimbursement rates to nursing facilities and intermediate care facilities for the mentally retarded and developmentally disabled is as described in the Nursing Facility Reimbursement manual which is Attachment 4.19-D, Exhibit B.

Payment Rates Resulting from Methods and Standards

1. Kentucky has determined that the payment rates resulting from these methods and standards are at least equal to the level which the state reasonably expects to be adequate to reimburse the actual allowable costs of a facility that is economically and efficiently operated.

2. The rates take into account economic trends and conditions since costs are trended to the beginning of the rate year (July 1) and then indexed for inflation for the rate year using Data Resources Incorporated inflation index.

3. Rates are established prospectively on July 1 of each year. Rates shall not be adjusted except for mandated cost changes resulting from government actions, to accommodate changes of circumstances affecting resident patient care and to correct errors in the rates (whether due to action or inaction of the state or the facilities). Rates shall be adjusted to an audited cost base if an unaudited cost report has been used due to new construction or other specified reasons which requires using an unaudited cost report.

4. The following special class of nursing facility is addressed in the Medicaid cost-based methodology regulation but is reimbursed according to methodology determined by federal regulations:

   A hospital providing swing bed nursing facility care is paid the average rate per patient day paid to free standing price-based nursing facilities for routine services furnished during the preceding calendar year.

5. The following special classes of nursing facilities are addressed in the Medicaid cost-based methodology regulation:

a. NF/Brain Injury Units means units recognized by the Medicaid agency as specially designated and identified NF units dedicated to, and capable of, providing care to individuals with severe head injury. Facilities providing preauthorized specialized rehabilitation services for persons with brain injuries with rehabilitation complicated by neurobehavioral sequelae means a facility appropriately accredited by a nationally recognized accrediting agency or organization. To participate in Kentucky Medicaid the facility or unit must be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

The all-inclusive rate for a brain injury unit is $360 per diem, excluding drugs and physician costs. These claims are to be submitted through the pharmacy and physician's programs. For those residents with brain injury and neurobehaviorial sequelae, the per diem is a negotiated rate not to exceed usual and customary charges. This rate excludes drugs and physician costs. These claims shall be submitted through the pharmacy and physician's programs.

b. Certified distinct part ventilator nursing facility unit means a preauthorized distinct part unit of not less than twenty (20) beds with a requirement that the facility have a ventilator patient census of at least fifteen (15) patients. The patient census shall be based upon the quarter preceding the beginning of the rate year, or upon the quarter precedent the quarter for which certification is requested if the facility did not qualify for participation as a ventilator care unit at the beginning of the rate year. The unit must have a ventilator machine owned by the facility for each certified bed with an additional backup ventilator machine required for every ten (10) beds. The facility must have an appropriate program for discharge planning and weaning from the ventilator. The fixed rate for hospital based facilities is $460.00 per day, and the fixed rate for freestanding facilities is $250.00 per day. The rates are to be increased based on the Data Resources Incorporated inflation index for the nursing facility services for each rate year beginning with the July 1, 1997 rate year.

6. The following special classes of nursing facilities are addressed in the Medicaid cost-based methodology regulation and are reimbursed at full reasonable and allowable cost in accordance with methodology determined by the state regulations:

   a. NF/Institutions for Mental Diseases (IMD) means facilities identified by the Medicaid agency as providing nursing facility care primarily to the mentally ill.

   b. NF/Dually licensed pediatric nursing facilities means facilities identified by the Medicaid agency as providing nursing facility care to residents under the age of twenty-one (21).

   c. ICF/MR/DD-Intermediate Care Facilities for Mentally Retarded and Developmentally Disabled means facilities identified by the Medicaid agency as providing care primarily to the mentally retarded and developmentally disabled.

7. The state will pay each provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the provider under the Plan according to the methods and standards set forth in this attachment.

8. Payments made in accordance with methods and standards described in this attachment are designed to enlist participation of a sufficient number of providers of services in the program. A sufficient number of providers assures eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public.

9. Participation in the program is limited to providers of service who accept, as payment in full, the amounts paid in accordance with the State Plan.

10. Payments will be made by Title XIX (Medicaid) for skilled nursing care for an amount equal to that applicable to Medicare Part A coinsurance amount for the twenty-first through 100th day of skilled nursing care. This amount will be reimbursed for patients who are eligible for Part A Medicare and admitted to an approved Medicare facility under conditions payable by Medicare.

Price-Based Nursing Facilities

The following facilities are reimbursed by the price-based nursing facility methodology:

a. A free-standing nursing facility;

b. A hospital-based nursing facility;

c. A nursing facility with waiver; and

d. A nursing facility with mental retardation specialty.

Cost Reports for Price-Based Nursing Facilities

Price-based nursing facilities must submit the latest Medicare cost report and the Medicaid supplement cost schedules attached to Attachment 4.19-D Exhibit-C. The Medicaid Supplement Cost Schedules are utilized for ancillary cost settlements. The Medicare cost report and Medicaid Supplemental Cost Schedules are utilized for historical data.

The Medicare cost report and Medicaid supplement schedules shall be submitted to the Department pursuant to time frames established in HCFA Provider Reimbursement Manual-Part 2 (PUB. 15-11) Section 102,102.1, 102.3 and 104.

Methods and Standards for Determining Price-based Nursing Facility Payments

The methods and standards for the determination of reimbursement rates to price-based nursing facilities is described in the Nursing Facility Reimbursement manual which is Attachment 4.19-D, Exhibit B.

Payment Rates Resulting from Methods and Standards

1. Kentucky has determined that the payment rates resulting from these methods and standards are at least equal to the level which the state reasonably expects to be adequate to reimburse the actual allowable costs of a facility that is economically and efficiently operated.
2. The standard price is market-based using historical data, salary surveys and staffing ratios. The standard price accounts for the higher wage rates for the urban area and the slightly lower rates for wages in the rural area.
3. The rates take into account economic trends and conditions since costs are trended to the beginning of the rate year (July 1) and then indexed for inflation for the rate year using Data Resources Incorporated inflation index.
4. The rate also takes into account a facility specific capital cost component based on an appraisal of each facility every five years. In a non-appraisal year, the R. S. Means Construction Index will be used to inflate the capital cost component.
5. The standard price shall be re-based every four year and consists of two components: the "case-mix" adjustable portion and the "non-case-mix" adjustable portion.

    (1) The "case-mix" adjustable portion consists of wages for direct care personnel, cost associated with direct care, and non-personnel operation cost (supplies, etc.).

(2) The "non-case mix" adjustable portion consists of all other facility cost except capital cost.

6. Case-mix is based on data extracted from the Minimum Data Set 2.0 submitted to the state survey agency as required by HCFA and the individual facility case-mix is calculated using the Resource Utilization Group (RUG) III version 5.12.

7. Rates are established prospectively on July 1 of each year and adjusted for "case-mix at the beginning of each quarter during the rate year (January, April, July, and October). A "case-mix" adjustment is the only adjustment made to the rates by the Department.

8. Other adjustments will not be made to the rates except for errors identified by the Department when computing the rate.

9. Facilities protection period shall be in effect until June 30, 2002. No price-based nursing facility will receive a rate under the new methodology that is less than their rate that was set on July 1, 1999, adjusted for the facility's "resident acuity". However, nursing facilities may receive increases in rates as a result of the new methodology as the Medicaid budget allows.

10. The new rate methodology must not exceed payments to the facilities for the period of January 1, 2000 to June 30, 2000 of $260,997,283. Subsequent rate periods will fall within the new biennium and will be subject to funding appropriated by the 2001-2002 biennium budget.

11. The Department remains at risk for increases in total nursing facility payments that result from higher utilization of beds by Medicaid recipients.

12. Payments made in accordance with methods and standards described in this attachment are designed to enlist participation of a sufficient number of providers of services in the program. A sufficient number of providers assures eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public.

13. The Department requires the submission of the Medicaid Supplemental Schedules included in the manual to be used for ancillary settlement. The Department shall require the submission of the most recent Medicare cost report and the Medicaid Supplemental Schedules included in the manual to be used for historical data.

14. Participation in the program shall be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the State Plan.

15. The state will pay each provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the provider under the Plan according to the methods and standards set forth in this attachment.

16. Payments will be made by Title XIX (Medicaid) for skilled nursing care for an amount equal to that applicable to Medicare Part A coinsurance amount for the twenty-first through 100$^{th}$ day of skilled nursing care. This amount will be reimbursed for patients who are eligible for Part A Medicare and admitted to an approved Medicare facility under conditions payable by Medicare.

PUBLIC PROCESS FOR DETERMINING RATES FOR LONG-TERM CARE FACILITIES

The State has in place a public process that complies with the requirements of Section 1902 (a) (13) (A) of the Social Security Act.

KENTUCKY CASE MIX ASSESSMENT AND REIMBURSEMENT SYSTEM

RESIDENT ASSESSMENT

INTRODUCTION

The Kentucky Department for Medicaid Services is implementing a new reimbursement system for price-based nursing facilities participating in the Medicaid program. These facilities included:

1. Free-standing nursing facility;
2. Hospital-based nursing facility;
3. Nursing facility with waiver; and,
4. Nursing facility with mental retardation specialty.

The new price-base reimbursement methodology will consist of a reasonable standard price set for a day of service for rural and urban facilities. This should provide an incentive to providers to manage costs efficiently and economically. The standard price includes:

1. Standardized wage rates;
2. Staffing ratios;
3. Benefits and absenteeism factors; and
4. "Other cost" percentages.

The new price-based reimbursement methodology is dependent on the specific care needs of each Medicaid and dually eligible Medicare resident in a nursing faciltiy. The new methodology will base the resident acuity using the Minimum Data Set (MDS) 2.0 as the assessment tool. The Resource Utilization Group (RUGs) is the classification tool to place resident into different case-mix groups necessary to calculate the "case-mix score". This methodology is based on a snapshot of facility's acuity on a particular point in time.

This methodology entails a re-determination of a facility's mix of residents each quarter in order to establish a new facility specific nursing rate on a quarterly basis.

One of the objectives of the new case-mix system is to mirror the resident assessment process used by Medicare and therefore not require the facilities to use two case-mix assessment tools to determine resident acuity. The second objective for using the MDS 2.0 and RUGS III is to improve reimbursement for facilities providing services for residents with higher care needs in order to improve access to care for these recipients.

There will be two major categories for the standard price:

1. Case-mix adjustable portion includes wages for personnel that provide or are associated with direct care and non-personal operation costs (supplies, etc.). The case-mix adjustable portion will be separated into urban and rural designations based on Metropolitan Statistical Area definitions.
2. Non case-mix adjustable portion of the standard price includes food, non-capital facility related cost, professional supports and consultation, and administration. These cost are reflected on a per diem basis and will be based on Metropolitan Statistical Area definitions.
3. Each July 1 the rate will be increased by an inflation allowance using the appropriate Data Resource Incorporated (DRI) index for inflation. The DRI will not be applied to the capital cost component.
4. Capital Cost Add-on:
   Each nursing facility will be appraised by November 30, 1999 and every five years thereafter. The appraisal contractor will use the E. H. Boeckh Co. Evaluation System for facility depreciated replacement cost. The capital cost component add-on will consist of the following limits:

   a. Forty thousand dollars per licensed bed;
   b. Two thousand dollars per bed for equipment;
   c. Ten percent of depreciated replacement cost for land value;
   d. A rate of return will be applied, equal to the 30-year Treasury bond plus a 2% risk factor, subject to a 9% floor and 12% ceiling; and
   e. In order to determine the facility-specific per diem capital reimbursement, the department shall use the greater of actual bed days or bed days at 90%.

For each July 1 rate setting in non-appraisal years, the department will utilize the R. S. Means Construction Index to adjust the capital cost component for inflation.

5. Renovations to nursing facilities in non-appraisal years:

   a. For facilities that have 60 or fewer beds, re-appraisals shall be conducted if the total renovation cost is $75,000 or more.
   b. For facilities that have more than 60 beds, re-appraisal shall be conducted if the total renovation cost is $150,000.

6. Facilities Protection Period

   a. Rate Protection - Until July 1, 2002, no NF shall receive a rate under the new methodology that is less than their rate that was set on July 1, 1999, unless a facility's "resident acuity" changes. However, NFs may receive increases in rates as a result of the new methodology as the Medicaid budget allows.
   b. Case Mix – Until July 1, 2000, no facility will receive an average case-mix weight lower than the case-mix weight used for the January 1, 1999 rate setting. After July 1, 2000 the facility shall receive the case-mix weight as calculated by RUGs III from data extracted from MDS 2.0 information.

7. Case-mix Rate Adjustments. Rates will be recomputed quarterly based on revisions in the case mix assessment classification that affects the Nursing Services component.

8. Case-mix rate adjustment will be recomputed should a provider or the department find an error.

TABLE OF CONTENTS